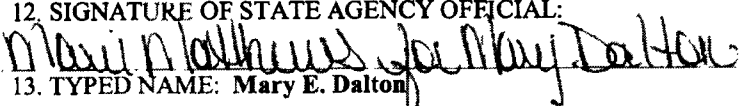



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-028	2. STATE Montana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 7/1/2013	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30)(A)		7. FEDERAL BUDGET IMPACT: a. FFY 13: \$ 102,830 b. FFY 14: \$ 418,170 c. FFY 15: \$ 436,699	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1A, Home Health Services 7a, b, c & d Attachment 3.1B, Home Health Services 7a, b, c & d Attachment 4.19B, Home Health Services 7a and 7b Attachment 4.19B, Home Health Services 7d		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1A, Home Health Services 7a, b, c & d Attachment 3.1B, Home Health Services 7a, b, c & d Attachment 4.19B, Home Health Services 7a and 7b Attachment 4.19B, Home Health Services 7d	
10. SUBJECT OF AMENDMENT: Amend Home Health Services to include an approximate 2% rate increase and to incorporate the fee schedule.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Single Agency Director Review.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Montana Dept. of Public Health and Human Services Mary E. Dalton State Medicaid Director Attn: Jo Thompson PO Box 4210 Helena, MT 59604	
13. TYPED NAME: Mary E. Dalton			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 9/18/13			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 6/27/13		18. DATE APPROVED: 9/23/13	
PLAN APPROVED ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/13		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: RICHARD C. ALLEN		22. TITLE: ARA, DMCHO	
23. REMARKS:			